Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

St. Joseph's Health Care London

3/31/2020

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

We are pleased to introduce St. Joseph's Health Care London's (St. Joseph's) 2020-21 Quality Improvement Plan (QIP), with a focus on effective transitions, patient and staff safety and building patient partnerships. Effective transitions initiatives at St. Joseph's include collaborating with external partners to develop supportive housing for transition of mental health inpatients after discharge and specific indicators and targets for transition of information to primary care after discharge. A long-term care target to reduce emergency department visits for specific ambulatory conditions also supports appropriate transitions in care and helps reduce system-wide impact on emergency departments and urgent care.

St. Joseph's focus on patient safety includes continuing the organizations goal to eliminate wrong drug / wrong patient medication errors. We have added a time-specific target related to completing structured debriefs following medication errors to support a safe culture for reporting medication errors. Through expanding medication reconciliation to specific ambulatory clinics, we are also ensuring patient safety. In addition, our target for completion of the Columbia Lifetime Suicide Severity Rating Scale for mental health inpatients aligns with St. Joseph's Zero Suicide Strategic Priority and focus on patient safety. Goals we've set to support reporting workplace violence incidents align with our strategic targets related to employee safety.

St. Joseph's strategic plan includes a key principle to purposefully partner with patients, residents and family caregivers. Our QIP supports this strategic priority by setting a target in 2020-21 related to recruitment and on-boarding of patient partners. Our long-term care indicators include targets for resident survey questions related to the voice of the resident and being able to express opinions, and our hospital workplan includes a target for a survey question to measure the patient perspective related to information about what to do if there are concerns after discharge in our Rehabilitation Programs.

Describe your organization's greatest QI achievement from the past year:

Improving Transitions in Care – Discharge

Considerable work was completed in 2019-2020 to improve the transition of inpatient rehabilitation patients from hospital. This included the information they, and their family caregivers, were given to guide their care after discharge. To accomplish this, Care Resource Binders, a communication tool used by patients, family caregivers and the care team throughout the patient's stay, were utilized in various ways such as the addition of one-page inserts with detailed discharge instructions and inclusion of various pamphlets and resources. Staff were made aware of the need for additional education and a lead staff member was assigned to review this information with patients and their family caregiver(s) at discharge.

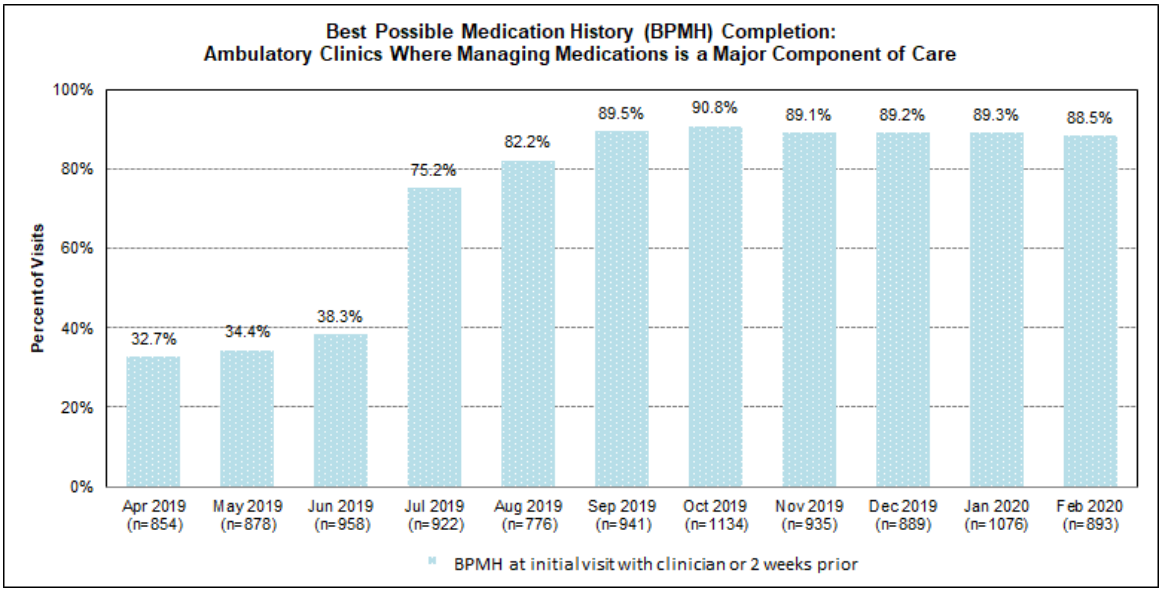
As well, St. Joseph's Outpatient Stroke Team piloted the formal use of patient-oriented discharge summaries. In addition, a number of strategies were implemented on St. Joseph's geriatric inpatient units to ensure patients and family caregivers know who to contact post-discharge.

Fridge magnets with key contact numbers for the patient's pharmacy, primary care provider and Home and Community Care team were included in discharge packages and post-discharge follow-up phone calls were made to patients within three business days of them leaving the hospital. Patients and family caregivers were involved in the development and testing of these communication and education tools. We have seen a positive increase in patients reporting they are receiving enough information about what to do and who to contact if they were worried about their condition once they have left the hospital from 41 per cent to 55 per cent over a one-year period from 2018-2019.

Medication Safety: Medication Reconciliation Highlights

Despite strong gains in prior years, medication reconciliation at inpatient admission and discharge remained a high priority for St. Joseph's. In our relentless pursuit of safety, we set an ambitious goal of 90 per cent and focused on both sustainability and the quality. It was identified that in addition to ensuring high completion rates, it was important to standardize the way medication history information was being collected for the medication reconciliation process. For this reason, we monitored the completion of the Best Possible Medication History (BPMH) before medication reconciliation. By definition, BPMH is differentiated from a simple medication list by the validation step using multiple sources of information, including a patient or caregiver interview. This important step elevated the accuracy of the information and increased medication safety on admission and discharge. With a better understanding of existing processes, greater data insight through reporting, and increased access to BPMH, St. Joseph's clinicians consistently met and surpassed the goal of 90 per cent for discharge medication reconciliation and achieved 87 per cent admission medication reconciliation with BPMH completed prior.

With increased confidence in our inpatient admission and discharge processes, we turned our attention to ambulatory services. Medication reconciliation in this setting, assures safe prescribing as well as consistent communication between providers inside and outside the hospital system. Similarly to the inpatient environment, quality medication reconciliation must start with a consistent approach to medication history information collection. By using a coordinated approach between prescribers, nurses, pharmacists and pharmacy technicians, St. Joseph's has been able to sustainably achieve BPMH completion rates close to 90 per cent for initial ambulatory visits (see graph below). By developing a standardized way to collect and record BPMH, St. Joseph's is well-positioned to improve medication safety and reach our target for Medication Reconciliation in the ambulatory clinics in the coming year.



Long Term Care Achievements

Mount Hope Centre for Long Term Care (Mount Hope) has a quality improvement strategy focused on key indicators that enhance resident safety, care and quality of life. These indicators include pain control and palliative care, skin and wound programs, falls, restraint and behaviour management and infection control. This year, Mount Hope has also committed to improving the resident admission process and the overall customer service for residents and families. Residents and families are encouraged to share feedback on their experiences at Mount Hope through various methods such as the resident and family councils and quality engagement surveys. One unique program that has improved the quality of the resident experience has been the establishment of a Resident Ambassador program (RA program). The RA program is designed to meet the individual needs of residents by providing them opportunities to serve meaningful roles and give back to their community. Resident ambassadors take on tasks such as being new resident greeters, offering support to residents of differing cultures, connecting Mount Hope to charitable causes and using their talents to enhance the delivery of therapeutic recreation programs.

In 2019-2020 we saw significant improvement in annual resident and family experience survey results. Mount Hope met and surpassed targets for all three indicators from the annual resident experience survey.

Collaboration and Integration

Leaders and care providers in St. Joseph's mental health care programs have been addressing the struggle faced by many patients who have no adequate discharge destination. These patients are considered "psychiatric ALC" or, essentially, "homeless in hospital" and account for 30 per cent of the organizations 154 occupied mental health beds. Because they are unsuccessful in their applications for community housing, these patients continue to occupy specialty mental health beds, even though they no longer need active treatment or rehabilitation making those beds unavailable to acute transfers. This impacts seven schedule one hospitals and the non-schedule one hospitals accessing mental health services in the region. A lack of vacancy in acute beds impacts flow from the emergency department, resulting in patients being housed in unconventional care space inadequate care environments and 'hallway medicine' in the ED for mental health patients.

Through advocacy, community facilitated focus groups and cross sectorial partnerships, such as that with Indwell, a charity that creates affordable housing communities, 66 supportive housing units have been be built. This strategy has helped improve the flow of patients, seeing the rate of long stay patients (more than 90 days) decrease.

We will continue to work with partners, to create additional high supportive housing units in 2020-2021, particularly for an identified sub population of homeless or precariously housed who have mental illness and co-morbid medical conditions.

Ontario Health Team Collaboration Highlights

The Western Ontario Health (WOH) team is a collection of patients and care partners including; primary care, community care, hospital and first responders who have collaborated to coordinate care for people with advanced Chronic Obstructive Pulmonary Disease (COPD) and Advanced Congestive Health Failure (CHF).

In its first year the WOH team committed to identifying two to three thousand patients with advanced COPD and/or CHF who need care coordination/navigation and are at risk of institutionalization. The WOH will offer these patients:

- Establishment of a sustained care relationship
- Co-creation of an individualized care plan (and accountability for ensuring it is carried out)
- A consistent point of contact for health concerns and system navigation
- A shared care record that they have access to and that is available to their care team (primary care, hospital-based providers, and home care providers at a minimum in year one)
- Access to:
    - urgent care
    - community paramedicine
    - two walk-in clinics

The team is working with the Change Foundation to develop a co-design strategy to meaningfully engage patients, caregivers and clinicians so together they can define the system-wide processes needed to identify patients, establish a sustained care relationship (especially with traditionally marginalized populations) and support them in their care journey.

Patient/client/resident Partnership and Relations

Patient Partnerships

Over the past four years St. Joseph's has had a significant focus on partnering with patients, residents and family caregivers. Grounded in a Care Partnership framework and a partnership with The Change Foundation, St. Joseph's has implemented several initiatives in 2019-2020 such as:

- **Continued spread of Care Binders.** Developed through a co-design process with staff members, patients and family care givers, the Care Binders are individualized for each patient at admission and updated throughout their stay. Upon discharge, the binder acts as a portable resource and record of the patient's journey for ongoing care needs. First implemented in Specialized Geriatric Services, the binder was spread to other program areas in 2019.

- **Family presence.** Launched in 2019, the family presence policy eliminated visiting hours and welcomes family caregivers at any time at St. Joseph's directed by the patient or resident, with quiet hours in place from 10 pm to 7 am to respect the healing environment.

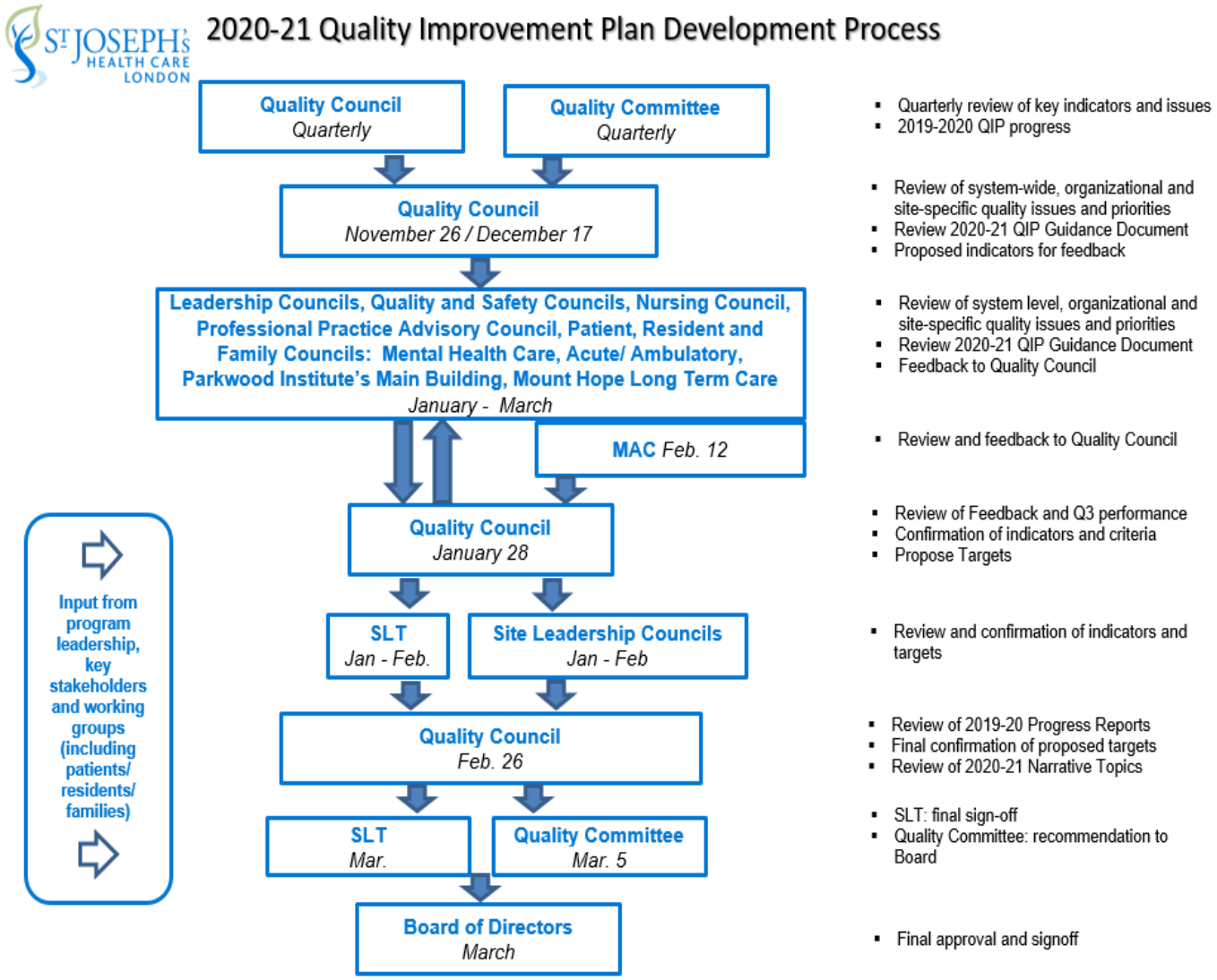
- **Health care provider education**. Four e-learning modules were developed with the Change Foundation on partnering with family caregivers. One module is mandatory for all staff to complete in 2020.

- **Patient and family partners.** A recruitment strategy for patient and family caregivers who want to become care partners was developed. We currently have 46 partners who will be matched to their area of interest such as quality improvement initiatives, member of a patient/resident/family council, or research with a goal to have 100 partners recruited, on-boarded and trained by March 31 2021.

To sustain this work, a Care Partnership office with dedicated staff and resourcing is being created by April 2020. This office will be responsible for ensuring patients, residents, families, and caregivers are engaged with health care providers in the design and delivery of care and services across all facets of the organization.

Engagement of Staff, Clinicians, Patients, Resident and Families

Our Quality Improvement Plan goals and indicators are shared with Patient and Family Councils and are developed with input from Councils and Leaders across the organization.



Workplace Violence Prevention

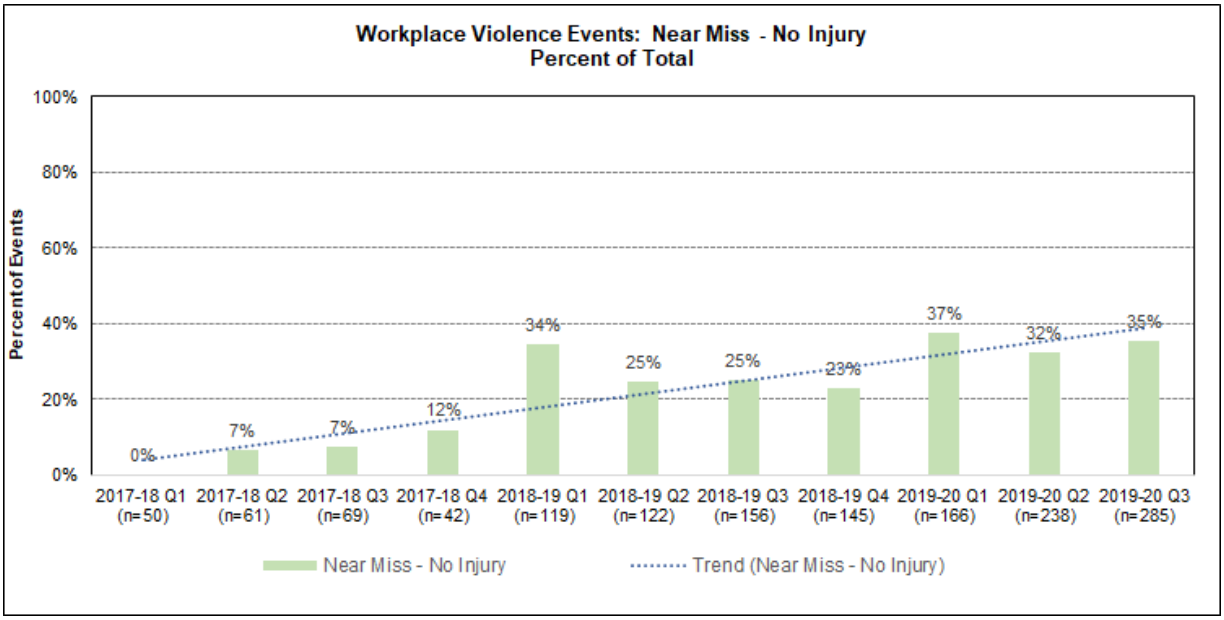
St. Joseph's QIP goal has focused on strategies to encourage and support reporting of all workplace violence events, and increasing staff's understanding of the value of individual patient risk assessment for responsive behaviour/violence - an essential component of workplace violence prevention and provision of high-quality care.

Multiple strategies have been critical to address significant under-reporting of workplace violence events at St. Joseph's such as the implementation of an electronic system to streamline reporting and responding to events. As well, through analyzing and following-up patient aggression events toward staff, the organization has provided education for staff on the importance of reporting and connecting risk assessments to care planning. This education is accomplished through existing structures such as daily safety huddles, the development of a Decision Aid tool on when to report workplace violence and a comprehensive staff training plan.

A new policy on Behaviour Safety Alert (BSA) Assessment and the electronic behaviour safety assessment tool (BSAT) were implemented at St. Joseph's in May 2019, designed in partnership with St. Joseph's patient, resident and family councils. From these assessments, clinical staff work with the patient and/or substitute decision maker(s) to create a care plan. Discussions with patients and families help identify behavioral triggers and strategies to better address their needs. As well, formal incident investigations are used to ask the patient about their perceptions of what happened and why.

There has been a significant improvement in the reporting of workplace violence events from an original baseline of 218, to 834 reported events from January 1 to December 31, 2019. A breakdown of reported events by severity level shows Hazardous Situation, Near Miss-No Injury and Minor Injury events have increased, while Health Care and Lost Time Injury severity levels decreased from 28 (2017) to 22 (2019).

A notable success has been an increase in the percent of Near Miss / No Injury workplace violence events from zero per cent in 2017-18 Q1 to over 30 per cent of the total reported events in each quarter in 2019-20. As we continue our goal to increase reporting for another year, a supporting goal will be to sustain the reporting of near miss events. Ensuring full adoption of standard processes for risk assessments and patient / resident care plans are key components to support the longer-term goal to reduce workplace violence events.



Virtual care

St. Joseph's Strategic Plan (2018-2021) includes a priority for virtual care that says, "By 2021 we will evolve future-state regional health care that blends specialized in-person care with distributed and virtual approaches, where needed, to bring care to where people are." Examples of past integration of virtual technology in care include using "smart" technology in rehabilitation apartments for patients with serious and persistent mental illness, "tele rehab" for stroke rehabilitation, and use of post-discharge phone calls to ensure that patients are receiving the care they need after an acute surgical stay.

While the organization is committed to utilizing virtual care, there has not been a formal framework in place to support the scale, spread and resourcing of these innovations. St. Joseph's is developing a Virtual Care Strategy through engagement with subject matter experts, patient and family councils, leadership councils and the organizations Medical Advisory Committee. A review of provincial, national and international research, guidelines and lessons learned has occurred, and a knowledge repository and identification of a network of champions is underway. Consideration has been given to internal and external initiatives that would align with a virtual care strategy including regional planning around Ontario Health Teams. As well, St. Joseph's partnered with the Ontario Telemedicine Network (OTN) to integrate virtual care tools such as Personal Computing Video Conferencing (PCVC) in four early adopter areas (Endocrinology, Geriatric Medicine, Rehabilitation and Mental Health). The primary goal of this initiative is to promote integration, timely access and improved patient and provider experience.

Executive Compensation

At St. Joseph's, leaders at all levels (coordinator, director, executive) have clearly established goals for 2019-2020 and where applicable, goals are aligned with QIP priorities. Targets, 90-day plans, and monthly tracking of progress are conducted with leaders.

Our executives' compensation is linked to performance in the following ways:

- President and Chief Executive Officer (CEO) has five per cent of annual salary compensation at risk related to achievement of annual QIP indicator targets outlined below.
- All executives (senior leaders reporting directly to CEO) have three per cent of their current annual salary compensation at risk related to the achievement of annual QIP indicator targets outlined below.
- Integrated executives (those who work at both St. Joseph's and London Health Sciences Centre) will have the three per cent of their annual salary at risk evenly split between each organization (50 per cent St. Joseph's and 50 per cent London Health Sciences Centre).
- The CEO and executives reporting to the CEO will have the same targets.
- The following four indicators from our hospital QIP will be tied to performance-based compensation:
    - number of patient partners recruited, trained and on-boarded via a standard corporate process
    - number of workplace violence incidents

- number of medication errors (wrong drug/wrong patient)
- percent of initial ambulatory clinic visits with Medication Reconciliation Completed

Compensation will be awarded as follows:

- The four indicators carry equal weight (each one is worth 25 per cent)
- For each indicator:
  - Less than 50 per cent of target achieved = none of the compensation at risk will be awarded for that indicator
  - 50 to 99 per cent of target achieved = compensation at risk will be awarded for that indicator pro-rated based on per cent of target achieved
  - 100 per cent or more of target achieved = 100 per cent of compensation awarded for that indicator

Indicator	Current	50 percent of Target	Target
Number of Patient Partners Recruited, Trained and On-boarded via a Standardized Corporate Process	46	73	100
Number of Staff Workplace Violence Incidents	834	939	1043
Number of Medication Errors (Wrong Drug/ Wrong Patient)	4	2	0
Percentage of Initial Ambulatory Clinic Visits with Medication Reconciliation Completed (all ambulatory clinics where managing medications is a major component of care)	49.2%	54.6%	60%

With consideration to the significant and potentially ongoing impact of COVID-19, the Board reserves the right to reconsider the executive compensation relative to the achievement of the four indicators listed**.**

Contact Information

Vivian Capewell,
Director, Quality Measurement and Clinical Decision Support

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Howard Rundle
Chair, Board of Directors

Brenda Lewis
Chair, Quality Committee of the Board

Gillian Kernaghan
Chief Executive Officer

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Hospital workplan

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Theme I: Timely and Efficient Transitions	**Timely**	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	714*	23.5	35.00	Baseline data shows an average time of 12 days impacted by longer outliers. A goal in year one of this initiative is to reduce the average time from discharge to signed off from 12 days to 6 days. A focus in year 1 on factors impacting outliers with very long turnaround time will shift the average. Change ideas impacting discharge summary turnaround times above but closer to 48 hours will have a further focus in year 2.		1)Enhance transcription services to increase the speed of transcription of dictated discharge summaries from an average of 24 hours and maximum of 48 hours to an average of less than 8 hours and a maximum of 8 hours.	1) Modify transcription contract with external transcription provider to prioritize the transcription of discharge summaries.	1) Transcription turnaround time, being the time between completion of dictation and completion of transcription, as measured by our external transcription provider and documented in our electronic health record for each patient discharge.	1) All discharge summaries transcribed within 8 hours of dictation, beginning April 1, 2020.	Contract modifications are complete and changes are being implemented by our external transcription provider.
											2)Develop monitoring tools to inform current performance, improvements realized and enable physician engagement.	2.1) Manually developed Excel-based tools for input/enhancement. 2.2) Automated Excel-based monitoring tools capturing input from stakeholders from manually developed reports. 2.3) Development of Quality Improvement Analytics as applicable.	2.1) Manually developed Excel based tools implemented. 2.2) Automated excel based tools implemented. 2.3) Quality Improvement Analytics reporting priorities determined.	2.1) Implement manually developed Excel-based tools in Q1 2020/21. 2.2) Implement automated Excel-based tools in Q3 2020/21. 2.3) Set quality improvement analytics reporting priorities for these monitoring tools in Q4 2020/21.	Periodic release of current state results and identified improvements to stakeholders at the reporting levels defined for this planned improvement initiative.
											3)Identify services for auto-authentication of transcriptions to accelerate turnaround time.	3.1) Engage site leadership councils to identify services interested in exploring auto-authentication. 3.2) Develop dictation and transcription templates for identified services and test for effectiveness. 3.3) Implement auto-authentication for services ready to transition following template development and testing.	3.1) Number of services identified for auto-authentication pilots. 3.2) Number of pilot services transitions to implement auto-authentication. 3.3) Percent of discharge summaries completed by pilot services following auto-authentication protocols.	3.1) Identify at least 4 services (or physicians) at each of St. Joseph's main sites with inpatient services (4) to pilot auto-authentication protocols by the end of Q1 2020/21. 3.2) Transition 50% of identified pilot services to auto-authentication for discharge summaries by the end of Q3 2020/21. 3.3) 50% of discharge summaries completed using auto-authentication of total discharge summaries completed by pilot services that transition to using auto-authentication for patient discharges occurring in these services during Q4 2020/21.	Auto-authentication involves the standardization of dictation and transcription structure/approach to reduce the need/prevalence of required edits post-transcription by the dictator. This enables the distribution of transcriptions immediately upon completion of transcription with a final review by the dictator occurring subsequent to the distribution to the primary care provider, eliminating the time period between transcription and authentication by the dictator.

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Hospital workplan

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Theme II: Service Excellence	**Patient-centred**	Number of New Patient and Family Partners Recruited and Completing Corporate On-boarding Process.	C	Number / Number by end of Q4 / New recruits to the organization as well as existing patient and family partners and Patient, Resident and Family Council members	Hospital collected data / 2019-20	714*	46	100.00	Based on completion of new recruitment as well as completion of standardized training and onboarding by existing patient, resident and family representatives on multiple Councils.		1)Launch recruitment materials to staff, patients and family partners.	1.1) Distribute materials to clinical program areas and support services; post on intranet and external website. 1.2) Attend staff and physician leadership meetings; and 1.3) Attend patient and family councils.	1.1)Percentage of areas that receive recruitment materials. 1.2) Number of leadership meetings attended. 1.3) Number of patient and family council meetings attended.	1.1)100% of areas receive recruitment materials by end of Q2; materials posted to intranet and website by end of Q1. 1.2) Information shared at leadership meetings by end of Q2. 1.3) All patient and family council meetings attended by end of Q2.	
											2)Audit and evaluate recruitment materials.	2) Develop assessment survey for staff and for patient and family partners.	2) Percentage of surveys completed; percentage positive results related to awareness and effectiveness of recruitment materials.	2) 20% survey response rate by end of Q3; 60% results are percentage positive related to awareness and effectiveness.	
											3)Develop standardized approach and process to training and onboarding patient and family partners including patient and family council members.	3) Conduct training and onboarding tools with new patient and family partners; identify existing partners who have not received training/onboarding and develop training opportunity.	3) Percentage of new and existing patient and family partners including patient and family council members who have completed training.	3) 100% of new patient and family partners have completed training and onboarding within one month of recruitment; 100% of existing patient and family partners including patient and family council members have completed training and onboarding session by end of Q4.	
											4)Leverage online leader toolkit as mechanism to educate and raise awareness regarding recruitment of patient and family partners.	4) Introduce leader toolkit at Care Partnership meeting in April 2020; post toolkit to intranet; include link to toolkit into new leader onboarding by end of Q1.	4) Number of unique website visits to online toolkit.	4) 200 unique website visits by end of Q3.	
		Percentage of respondents who responded "completely" to the following question, Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital.	C	% / Survey respondents - Specialized Geriatrics & Rehabilitation Programs	CIHI CPES / Most recent available results (2019-20 Q2)	714*	55	58.00	Continue to improve performance		1)Implement bundle of transition plan initiatives: Patient Oriented Discharges (PODs)	Patient Oriented Discharges (PODs): 1.1) Co-design with patients, family members and staff what needs to be on a POD. 1.2) Implement using a Plan-Do-Study-Act (PDSA) cycle approach. 1.3) Finalize a plan for sustainability.	1.1) Co-design of PODs including patients, family members and staff completed. 1.2) # of teams using PODs; % of patients who receive POD summary. 1.3) Plan for sustainability drafted.	1.1) Co-design work completed by end of Q2. 1.2) N = 4 Inpatient Coordinators; by Q3 70% of patients will have a POD completed at time of discharge. 1.3) Plan for sustainability drafted by end of Q3.	
											2)Implement bundle of transition plan initiatives: Teach Back by staff to patients/family members	2) Teach back: Confirm a train the trainer model for building capacity amongst staff for completing teach back. Identify tools/resources to support. Co-design the process and documentation to ensure there is clear accountability by staff, patients and family upon completion.	2) # of Champions who will be trainers; # of staff trained on teach back methodology	2) N=5 Coordinators (Inpatient and Outpatient) by Q3, 75% of patients will receive health teaching information using teach back methodology.	

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											3)Implement bundle of transition plan initiatives: Follow up phone calls.	3) Follow up phone calls: Design and implement processes to complete follow up phone calls for patients being discharged from an inpatient bed.	3) # of teams using follow-up phone calls	3) 60% of teams will be using follow-up phone calls	
											4)Using co-design approach, continue to revise/spread Transition Binders across all program areas.	4) Co-design with patient/family caregivers and staff what needs to be in the binder (or revised/deleted).	4) % of teams who demonstrate use of co-design with patient, family caregivers and staff to evaluate/revise binder throughout the year in an effort to sustain this practice.	4) 100% of inpatient and outpatient teams.	

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Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	714*					1)				With a better understanding of existing processes, greater data insight through reporting, and increased access to the Best Possible Medication History (BPMH), St. Joseph's clinicians consistently met and surpassed the goal of 90 per cent for discharge medication reconciliation. We will continue to monitor this indicator internally to ensure sustainability.
		Percentage of initial ambulatory clinic visits with medication reconciliation completed	C	% / Initial appointment with a prescriber in an ambulatory clinic where managing medications ia a major component of care	Electronic Health Record Documentation / October - December 2019 (Q3)	714*	49.2	60.00	Volume of appointments is much higher at St. Joseph's Hospital and performance overall will reflect completion of medication reconciliation at St. Joseph's Hospital.		1)Engage patient and family councils in developing strategies to support effective collection of medication history prior to or at the initial visit in the ambulatory clinics where medication management is a major component of care.	1) Attend patient and family councils to explain the importance of collecting accurate information, share initiatives, and gather feedback.	1) Number of patient and family council meetings attended.	1) All councils attended by the end of Q3.	
											2)Optimize quality improvement analytics.	2.1) Enhance quality improvement analytics. 2.2) Evaluate the process for the access and distribution of quality improvement analytics. 2.3) Establish appropriate frequency of distribution. 2.4) Define metric follow-up process and responsibilities.	2.1) Enhancement to quality improvement analytics completed. 2.2) Identify and train specific groups of stakeholders requiring access to quality improvement analytics. 2.3) Distribution processes defined and optimized. 2.4) Responsibility for metric follow-up established and occurring regularly.	2.1) Enhancement completed in 2019-20 Q4. 2.2) Specific stakeholders identified and trained by the end of Q1. 2.3) Distribution process optimized by the end of Q2. 2.4) Responsibilities for a regular follow-up established by the end of Q3.	
											3)Review ambulatory clinic workflows and identify barriers.	3.1) Review current state workflows within the ambulatory clinics where managing medications is a major component of care. 3.2) Identify specific barriers to documenting Best Possible Medication History and completing Medication Reconciliation.	3.1)Number of clinics with reviewed current state workflows completed. 3.2)Barriers identified, documented, and shared with site leadership.	3.1) 50% of ambulatory clinic workflows reviewed by the end of Q2. 3.2) Barriers identified, documented, and shared by the end of Q3.	
											4)Engage ambulatory clinic prescribers and physician leaders in promoting the importance of medication reconciliation.	4.1) Define physician leader responsibilities in promoting compliance with the medication reconciliation processes in ambulatory clinics. 4.2) Add medication reconciliation as a standing agenda item to all departmental medicine meetings.	4.1) Physcian leader responsibilities defined. 4.2) Medication Reconciliation added to all departmental medicine meetings involving prescribers.	4.1) Define physician leader responsibilities by the end of Q2. 4.2) Add medication reconciliation as a standing agenda item to the departmental medicine meetings by the end of Q3.	

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	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**714***	**834**	**1043.00**	**Recommendation to continue to have a target that is greater than the previous year, but reduce the amount of increase to 25% over 2019 actual.**		**1)Complete assessment (continued from 2019-20) of current training needs and ensure appropriate training is being provided for prevention and intervention in crisis situations.**	**1) Identify training offerings/methods to address all gaps for all main clinical programs and key support services.**	**1) Training needs and architecture in place.**	**1.1)Training (enhancements or new) confirmed by end of Q2; 1.2) Training program changes completed by end of Q3.**	
											2)Develop integrated analytics for leaders to support hard-wiring of standard processes and analysis of workplace violence incidents and efficient follow-up.	2.1) Leader and other stakeholder engagement to determine requirements. 2.2) Identify key data elements from multiple systems. Design, build and test key measures. 2.3) Build a self-serve report that updates nightly, provides key measures and trends with drill down to integrated information that enables immediate follow-up and insight into factors impacting workplace violence events.	2.1) Requirements confirmed. 2.2) Development and testing of measures completed. 2.3) Report in production and leader orientation completed.	2.1) June 2020. 2.2) August 2020. 2.3) October 2020.	
											3)Utilize Code White information and Cerner Behaviour Safety Alert (BSA) to identify events that should be reported in Workplace Occurrence Reporting System (WORS).	3.1) Code White debrief includes discussion on requirement to report incident in WORS. 3.2) Include information on reporting requirements in education on BSA roll out. 3.3) Assess feasibility of reviewing newly added BSAs to determine if WORS was required and reported.	3.1) Percentage of Code White debriefs with documented confirmation of discussion on requirement to report in WORS. 3.2) Percentage of identified audience trained on BSA training includes information on requirement to report.	3.1) 100% of Code White debriefs have documentation on WORS requirement by Q3. 3.2) 100% of identified audience is trained on use of BSA and requirement to report in WORS by Q4.	
											4)Evaluate use of the electronic screening tool (Behaviour Safety Alert Tool or BSAT) and completion of safety plan documentation.	4.1) Analysis of data to examine relationship between workplace violence events, BSAT risks, and presence of safety plan. 4.2) Analyze trends for patients with responsive behaviours and safety plan.	4.1 & 4.2. Project timelines.	4.1 &4.2. Analysis completed by Q3.	
											5)Highlight value of Near Miss-No Injury reporting and follow-up.	5) Percentage of workplace violence events severity level Near Miss - No Injury will be reported on St. Joseph's Corporate Scorecard with a target to maintain at 30% or more of total events.	5) Timeline to initiate reporting.	5) Reporting initiated as of Q1.	
											6)Continue engagement of patients , Residents and families, including discussion of triggers and perception of what happened.	6) Audit of sample documentation in multiple programs.	6) Audit completed by target date.	6) Audit completed by Q3.	

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Hospital workplan

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		Number of Medication Errors Classified as Wrong Patient/Wrong Drug	C	Number / All inpatients receiving medication administration	Patient Safety Reporting System / October to December 2019 (Q3)	714*	4	0.00	Best possible performance. Closed loop medication administration (CLMA) is implemented in all hospital inpatient units (Mount Hope Centre for Long Term Care excluded)		1)Improve timeliness of debriefs.	1.1) Engage coordinators in reviewing current debrief process to assess for areas for further improvement. 1.2) Assess and implement improvement ideas. 1.3) Monitor and evaluate debrief completion time.	1.1) Engagement strategy developed and completed. 1.2) Ideas analyzed and Implementation started. 1.3) Percentage of debriefs completed within 10 business days.	1.1) Done by end of Q1. 1.2) Done by end of Q2. 1.3) 75% of debriefs completed within 10 business days by Q3.	
											2)Share learnings in a consistent way across the organization.	2.1) Practice consultant at each debrief / involved in review of all relevant medication events. 2.2) Use information gathered at medication events to generate "Med Safety Minute" bulletins that can be used to share information across the organization. 2.3) Evaluate the use of "Med Safety Minute" bulletins as a way to share learnings / enhance process.	2.1) Percentage of practice consultants at each debrief/involved in review. 2.2.1) Complete and distribute monthly bulletins to identify key learnings from med event debriefs. 2.2.2) Develop strategy to evaluate use. 2.2.3) Obtain feedback on use of bulletins. 2.3) Compile recommendations to enhance use of bulletins / other methods.	2.1) 100% by end of Q1. 2.2.1) 100% monthly bulletins completed and distributed by end of Q1. 2.2.2) Strategy developed by end of Q1. 2.2.3) Feedback obtained by the end of Q2. 2.3) Recommendations compiled by end of Q3.	
											3)Improve compliance for patient and medication scans; performance manage low preforming staff.	3) Develop clear and consistent messaging regarding scanning expectations, resources to help support best practice and consistent performance management strategies for those who continue to underperform.	3) Percentage of patient and medication scanning compliance.	3) 95% scanning rate compliance for patients and medications.	
		Percent of specific medication errors with a debrief completed within 10 business days	C	% / Hospital inpatient medication administration errors: all wrong drug / wrong patient medication errors and all other types of medication errors with severity level 3/4/5. Mount Hope Centre for Long Term Care excluded.	Hospital collected data / October to December 2019 (Q3)	714*	20	75.00	Goals for debrief completion include additional types of medication errors to maximize learning opportunities.		1)Enhancement to Patient Safety reporting System (PSRS) and reporting.	1.1) Enhance PSRS to Include Debrief Date/Time. 1.2) Audit report developed and distributed to professional practice.	1.1) Enhancement completed. 1.2) Reporting and distribution completed.	1.1) Enhancement completed by end of Q1. 1.2) Reporting and distribution completed by end of Q1.	
											2)Professional Practice to assist leaders in the identification of QIP med errors that require a formal debrief and provide supports and recourses in completing timely debriefs.	2) Professional practice to monitor for QIP med errors, flag these med errors to leaders and support the debrief process.	2) Process for flagging and supporting med error debriefs with leaders completed.	2) 100% of QIP med errors flagged to leaders, Medication Event Debrief (MED) process resources provided, assistance provided to conduct formal debrief starting in Q1.	
											3)Develop strategies and processes to support "real time" or "near real time" debriefs.	3.1) Develop a process to support "real time" or "near real time" debriefing during regular business hours. 3.2) Develop a process to support "real time" or "near real time" debriefing outside of regular business hours. 3.3) Engage leaders in the development of this pathway, engage professional practice consultants and pharmacy in finding ways to prioritize this commitment. 3.4) Develop a special Med Safety Minute bulletin to help communicate the process and benefit of "real time" or "near real time" debrief.	3.1) QIP errors that occur Monday to Friday, between 8-4 will endeavor to be followed by a "real time" or "near real time" medication event debrief. 3.2) QIP errors that occur outside of business hours will endeavor to be followed by a "real time" or "near real time" medication event debrief. 3.3) Feedback and ideas gathered from leaders will be collected and reviewed and used to improve the process. 3.4) Communication outlining "real time" or "near real time" debriefing will be sent to leaders	3.1) 100% of QIP errors occurring during business hours are debriefed the same shift by the end of Q1. 3.2) 50% of QIP errors occurring outside of business hours are debriefed the same shift by the end of Q3. 3.3) 100% of leaders involved in debriefs and all leader groups will be engaged by end of Q1. 3.4) Communication regarding "real time" or "near real time" debrief will be sent out early in Q1.	

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Hospital workplan

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
		Percentage of Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime Assessments complete within 3 days of inpatient admission.	C	% / Mental Health inpatients. Parkwood Institute and Southwest Centre for Forensic Mental Health included. One Geriatric Psychiatry Unit (H2) and one Dual Diagnosis Program Unit (G5) are excluded.	Manual data collection / 2019-20 Q3	714*	49.6	75.00	Maintaining the target from 2019-20. Specific improvement target for inpatients in 2020-21.		1)Improve the quality of C-SSRS Lifetime assessments.	1.1) Education: Complete and disseminate new e-learning module for staff. 1.2) Provide clinicians with specific feedback in regards to learning opportunities. 1.3) Identify and train Zero Suicide Champions in clinical areas. 1.4) Best Practice and FAQ flyers disseminated quarterly for clinicians and leaders. 1.5) Focus groups and second administration of Workforce Survey completed with clinicians (including acceptable rationale explanations). 1.6) Collaboration with Clinical Informatics (CI) and Information Technology Services (ITS) to improve user functionality of C-SSRS Lifetime. 1.7) Policy revisions to articulate clinician and leadership accountability. 1.8) Standardized methodology to improve rigor of data collection.	1.1) Percentage of clinicians that complete the E-learning module. 1.2) Percentage of clinicians provided with feedback for incomplete assessments within one month. 1.3) Number of identified and trained Zero Suicide Champions. 1.4) Number of quarters with a flyer disseminated. 1.5) Focus group data and a target of 50% completion rates for follow up Workforce Survey to inform future Plan Do Study Act (PDSA) cycles. 1.7) Policy revision completed and approved by mental health leadership.	1.1) Ninety percent of required staff will complete e-learning module by end of Q2. 1.2) 100% of clinicians with incomplete assessments will receive follow-up feedback within one month. 1.3) 100% of identified Champions will be trained by end of Q1. 1.4) Flyer disseminated every quarter beginning Q1. 1.5) Increase understanding of strategies/challenges/barriers to C-SSRS quality completion and evaluate degree of staff learning (Workforce Survey) to inform future PDSA by end of Q1. 1.7) Revised policy uploaded to policy manager by end of Q1.	
											2)Increase the number of C-SSRS Lifetime assessments completed within 3 days of inpatient admission.	2.1) Develop self-serve analytics. 2.2) Enhance leadership/delegate engagement and accountability (electronic data reporting). 2.3) Standardize methodology to improve rigor of data collection. 2.4) Audit compliance on a monthly basis and follow-up with clinicians to address barriers to timely completion.	2.1) Within project milestone dates - develop, test, and launch self-serve reports which update daily. The reports will include drill down capability to provide actionable information for leader follow up. 2.2) Percentage of leader/delegate's who complete a quarterly action plan if not meeting the QIP target (75%). 2.3) Standardized data collection purposes. 2.4) Percentage of assessments incomplete within specified timeframe receiving follow-up within one month of deadline.	2.1) Complete project and launch by April 1, 2020. 2.2) 100% of leaders/delegates will complete a quarterly action plan if not meeting the QIP target. 2.3) All data methodology is standardized for data collection purposes. 2.4) 100% of all incomplete assessments receive follow up within one month.	
											3)Modifications to acceptable rationales for not completing the C-SSRS Lifetime assessment.	3.1) Advocate to expand acceptable rationale options for not completing the C-SSRS in collaboration with ITS/CI based on 2019-2020 data findings. 3.2) Provide feedback to individual clinicians and teams regarding what constitutes valid clinical rationale.	3.1) Number of additional acceptable rationale that are built into Cerner. 3.2) Percentage of clinicians and teams receiving communication related to valid clinical rationale.	3.1) 100% of suggested acceptable rationale are built into Cerner. 3.2) 100% of clinicians who did not accurately complete rationale section receive feedback, and 100% of teams receive re-education.	

2020/21 Quality Improvement Plan
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St. Joseph's Health Care London - Hospital workplan

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											4)Enhance leadership engagement and accountability in regards to clinician education and performance management.	4.1) Leaders will develop quarterly LEM goals and action items to achieve the QIP target. 4.2) Quarterly progress report sent to leadership.	4.1) Number of quarterly LEM goals completed by leaders. 4.2) Number of quarterly progress reports disseminated to leaders.	4.1) 100% of leaders who have not achieved the QIP target will have completed a quarterly LEM goal. 4.2) Quarterly progress report disseminated to leaders every quarter beginning Q1.	

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Long term care workplan

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Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2018 - September 2019	53885*	25.1	22.00	Additional improvement		1)Implement Internal Data Collection Process.	1) Establish internal monitoring system to track and trend Emergency Department (ED) visits.	1) Count the number of ED visits and review the data on a monthly and quarterly basis. Summary of reports of ED visits reviewed and analysis to be provided to Professional Advisory Committee and Quality Council on a quarterly basis.	1) 100% ED visits reviewed each quarter.	
											2)Ensure resident access to appropriate resources, services, assessment and treatment with the goal of consistency and compliance with Ministry of Long Term Care needs.	2.1) Review the current Mount Hope Physician Model in collaboration / consultation with the Medical Director and attending physicians. 2.2) Re-orient physicians to the goal of reducing ED visits.	2.1) Progress will be measured by the number of physicians consulted in the physician model review. 2.2) The number of physicians re-orientated to the goal of reducing ED visits.	2.1) 100% of Physicians consulted by Q2. 2.2) 100% of Physicians re-orientated to the goal of reducing ED visits by Q3.	
											3)Palliative Approach to Care in Long Term Care Project (PAC-LTC)	3.1) Implement education and training to improve staff palliative care knowledge, including assisting residents and families in advanced care planning, improving staff clinical assessment skills as residents approach end of life, and enhancing in home treatment and assessment of palliative care needs in order to have residents remain at Mount Hope through their last days. 3.2) Review data of Mount Hope resident deaths.	3.1) The number of staff who receive education and training to improve their palliative care knowledge. 3.2) Analysis of the number of residents who die at Mount Hope and the number of Mount Hope residents who die in hospital.	3.1) 100% of staff receive education and training by Q3. 3.2) A 5% reduction of Mount Hope residents who die in the Hospital by Q3.	
											4)Implement annual health assessment education for nursing team in order to improve knowledge and confidence in health assessments and clinical skills.	4) Implement education program for nursing team utilizing in-home resources, i.e., the Mount Hope Clinical Best Practice Lead, and community resources, such as St. Joseph's Health Care (SJHC) London registered staff to provide education and training for Mount Hope registered staff, in order to improve ability and confidence in health assessments and clinical skills.	4) Progress will be measured by the number of nursing staff who attend annual education and training on health assessments and clinical skills. Education will be offered annually.	4) 100% of full-time and part-time nursing staff trained in health assessments and clinical skills by Q3.	
Theme II: Service Excellence		Percentage of residents responding positively (% 9 + 10) to the question, "What number would you use to rate how well the staff listen to you?"	C	% / LTC home residents	NRC Health Long Stay Resident Experience (LSRE) survey custom question / November 2019	53885*	51.7	55.00	Additional improvement		1)Ensure understanding of Residents Rights and Person Centered Care, as well as Through Our Eyes (OARC) concepts.	1.1) Consultations with Resident Council and Family Council for their input and advice. 1.2) Full Implementation of education program for residents and staff using the Through Our Eyes (OARC) concepts. 1.3) As part of consultation with both councils, develop an implementation and communication plan to support residents and their families.	1.1) Consultations with Resident and Family Councils held. 1.2) The number of staff attending the prescribed training. The number of residents and families attending educational opportunities. 1.3) Communication plan developed and implemented.	1.1) Consultations complete by end of Q2. 1.2) 100% of all staff receive the training by Q3. Residents and families offered the training by Q3 (the number of residents and families in attendance will be tracked). 1.3) Communication plan developed by Q2 and implemented in Q3.	

2020/21 Quality Improvement Plan
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		Percentage of residents who responded positively (% Most of the time + Always) to the statement, "I can express my opinion without fear of consequences."	C	% / LTC home residents	NRC Health Long Stay Resident Experience (LSRE) survey custom question / November 2019	53885*	81.1	84.00	Additional improvement		1)Ensure consistency and understanding of Residents Rights and Person Centered Care	1.1) Consult with Resident Council and Family Council for their input, ideas and advice on Residents Rights and Person Centered Care. 1.2) Development and implementation of education program for residents on their rights to be presented at admission to Mount Hope and annually.	1.1) The number of councils collaborated with to develop and establish education program for residents on their rights. 1.2) The number of educational opportunities provided to residents and families on admission and annually. The number of residents and families attending educational opportunities.	1.1) Family and Resident councils consulted by Q2. 1.2) 100% of admissions receive education program. Education program offered 2 times per year to residents and families, with the number of residents and families in attendance recorded.	
											2)Ensure Complaints Management Program and follow up is effective	2.1) Review of complaints management program, including review of audit tools and current tracking process. 2.2) Review and analysis of current complaint tracking process.	2.1) The number of auditing tools evaluated for compliance with policy. The percentage of audits demonstrating 100% compliance rate. 2.2) The number of complaints tracked, trended, analyzed and actioned on a quarterly basis.	2.1) 100% of audit tools with compliance to policy by Q2. 2.2) 100% of all complaints tracked and reviewed by Q3.	
Theme III: Safe and Effective Care		The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / LTC home residents	Local data collection / Most recent 6 month period	53885*	0.74	0.85	Improvement		1)Mandatory Palliative Performance Scale (PPS) assessment to be completed and documented in electronic system on all new admissions to Mount Hope.	1) Re-education to ensure all nursing staff will complete PPS assessment on all new admissions and record the date / score.	1) The number of new admission residents who have a PPS score recorded in the system.	1) 100% of all new admissions will have a PPS score recorded in the system each quarter.	
											2)Implement standard process to identify residents with scores of 40 or below on the Palliative Performance Scale (PPS) who should flag an initiation of End of Life Care processes.	2.1) Develop standard process to identify residents with scores of 40 or below on the PPS who should flag an initiation of End of Life Care processes. 2.2) Communicate standard process and educate staff to complete and document the PPS score on all new admissions, as well as residents with significant changes, in order to flag those residents who have scores of 40 or below and require initiation of End of Life Care processes.	2.1) PPS / End of Life standard process development completed and approved by Mount Hope Palliative Care committee. 2.2) The number of staff educated on the new standard process.	2.1) Standard process development and approval completed by Q2. 2.2) 100% of staff educated by Q3.	